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ABSTRACT

The paper presents the multi-factorial problem of sexual abuse of children within their families, provides definitions of relevant terms (incest, sexual abuse, sexual misuse, molestation, sexual assault, rape), reviews the epidemiology of sexual abuse and its effects, and traces development of a Sexual Abuse Resource Team in a rural/resort New Hampshire community. It is noted that although the problem of sexual abuse has been referred to as a growing problem of "epidemic" proportions, this is attributable in large part to the fact that recognition and reporting of sexual abuse has significantly increased during the last 20 years. The various factors contributing to the etiology of sexual abuse are discussed and it is concluded that appropriate therapeutic response extends beyond any social, rehabilitative, or mental health service acting in isolation. This need for concerted action is cited as the reason for developing a systematic response, or protocol, to maximize opportunities for comprehensive and therapeutic investigation and outcome in rural communities where services are often limited. The discussion about the rural New Hampshire Sexual Abuse Resource Team addresses the crucial skills clinical social workers need to design, organize, and implement such a program. A diagram highlights how the protocol can be developed. (BRR)

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A systemic approach to the development of a sexual abuse protocol in a rural community:
An examination of social work leadership practice.

ABSTRACT:

The sexual abuse of children in their family is a multi-factorial problem, extending beyond the individual pathology of the offender. While the factors contributing to the etiology are varied, likewise the therapeutic response extends beyond any of the social, rehabilitative or mental health services acting in isolation.

A systemic response of protocol for addressing the problem is required to maximize the opportunity for a comprehensive and therapeutic investigation and outcome. The often limited but frequently familiar services available in rural community make the development and utilization of such a protocol in these settings particularly important.

This paper will also address the crucial skills which can be utilized by clinical social workers who may be familiar with the clinical expertise to address sexual abuse in families but not the organizational, to design and impliment such procedures.

Outline

A systemic approach to the development of a sexual abuse protocol in a rural community: An examination of social work leadership practice.

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I. Introduction

The sexual abuse of children within their family is a multi-factorial problem which extends beyond the individual pathology of the offender. The occurrence of such abuse is often indicative of some form of family dysfunction as well. While the factors which contribute to the etiology of the problem are varied, the subsequent societal response and interventions are likewise multi-dimensional. It is these responses which play a significant role in determining the ultimate degree of emotional support and equilibrium which the victim, family, and offender are able to achieve following the discovery of sexually abusive environment. The theoretical and clinical approaches to the problem of sexual abuse of children within a family have begun to view the problem from a systemic approach, while the application of protective, legal, and therapeutic services unfortunately do not. The inability to coherently and judiciously develop and implement a systemic protocol for responding to the sexual abuse of children within their family, can further traumatize the child and perhaps create emotional stress and disorders which exceed those caused by the sexual abuse itself.

The goal of this paper is to describe the role of clinical social work (practice) in the organizational development of a systemic community response to the sexual abuse of children. The focus of the paper will be on the (leadership) role utilized to facilitate the development of a sexual abuse protocol and I will use my own experiences in a rural/resort community in central New Hampshire as an example. The paper will begin with a brief review of the problem of sexual abuse of children and will begin with a clarification of definitions frequently used in dealing with the subject. Section II will review some of the crucial epidemiological factors and its effects upon the victim, offender and family. That review will attempt to validate the need for established protocol and procedure for dealing with this form of abusive behavior. Section IV will then present the role and

task that the author assumed in the development of a sexual abuse protocol in the particular setting described. It is also the intention of this paper that by identifying the skills and procedures used in assessing the problem, the factors prohibiting its resolution and those used in resolving the problem, a methodology can be developed for use in other similar situations.

A. The Problem

The problem of sexual abuse has been referred to as a growing problem of "epidemic" proportions. This is attributable in large part to the fact that recognition and reporting of sexual abuse has significantly increased throughout the past twenty years. In addition to whatever social or individual pathologies exist which contribute to the sexual abuse of children, the "last taboo" which sexual abuse has been referred to as, seems to be diminishing somewhat, resulting in increased awareness of the extent of the problem and its effects. While there may be no greater incidence of sexual abuse in the population than there was twenty years ago (the data is unavailable), the reporting of sexual abuse has increased by a ratio of 1.9/per million to 40/per 1 million in that time. The figures remain low for a variety of reasons. The taboo, the societal reactions and family disruption, the lack of available help, guilt feelings of the participants and the reality of criminal punishment all contribute. These factors have not only influenced the offenders and victims but those who might be in a position to report suspected abuse as well; such as family, friends, physicians, teachers, mental health clinicians, etc. Reports of some adults who were sexually abused as children also substantiates the low incidence of reporting sexual abuse. Devine (1980) writes that a retrospective study of 1,200 college age women indicated that 26% reported sexual experience with an adult prior to age thirteen yet only six percent of those incidents were reported. The

cumulative effects of all of these factors have produced low ratios of reporting sexual abuse and a wide discrepancy in treatment philosophies and modalities.

In order to benefit the reader with the nature and degree of the problem, a review of some of the definitions and epidemiological factors involved in the sexual abuse of children will follow. This data is by no means exhaustive, but can provide a basis for better understanding the underlying need and rationale behind the development of the protocol.

Definitions

It is extremely difficult to operationalize a definition of sexual abuse. Not only are the definitions a combination of mental health, medical and legal input and terminology but the laws governing and defining such activity vary from one culture to another and in this country from one state to another. For example, all states forbid contact between blood relatives while only some extend that to include non-blood relatives such as in-laws or step-family.

"Incest" in the broadest definition refers to the inappropriate sexual relationship between members of a family; such as that between a parent and child, extended adult family members and a child or between siblings. The term "sexual abuse" has come to be accepted as a broad definition of the sexual mistreatment of children. Sexual abuse can be defined as any sexual activity or stimulation inappropriate for that child's age and role in the family (within the context of the ethnic and socio-cultural environment). That sexual activity or stimulation varies from events where the child is an observer of the activity of others; is observed by others; general physical and tactile stimulation, to in the most extreme form, genital stimulation and manipulation.

The term "sexual abuse" is somewhat misleading in that children are not always abused with the accompanying physical components of malicious assault, physical injury or trauma. Some prefer to term "sexual misuse" of children to imply the occurrence of any of the activities noted above without physical violence and the term sexual abuse to be restricted to cases in which the child is in fact the object of an aggressive or sadistic attack. For the purpose of this discussion, however, the term sexual abuse will be used, as it represents the more culturally accepted definition of inappropriate sexual activity involving a child, which can include but is not restricted to situations where physical injury had occurred. The definition offered by Kemp (1978) is: "Sexual abuse is defined as the involvement of dependent, developmentally immature children and adolescents in sexual activities they do not fully comprehend, to which they are unable to give informed consent, or that violate social taboos or family roles."

The following broad definitions are also offered to the reader in this discussion:

- Molestation: sexual contact without intercourse.
- Sexual assault: manual, oral or genital contact by the offender with the victim without consent.
- Rape: assault where the penis or genitalia of the assailant is introduced with the genitalia of the victim through fear, force or fraud.

II. Epidemiology

The Victim

The empirical data regarding the effects of sexual abuse upon children is in its own infancy. Complications in collecting such data are limited to only what is believed to be the small percentage of cases that are actually reported and in treatment. The fear of perpetuating a trauma by subjecting the child to extended intrusive follow-up studies limits longitudinal studies in this area. The majority of the studies on the effects of sexual abuse are done with adult women who enter treatment for this or other identified problems and report the abuse as a secondary complaint.

The reported psychological effects of sexual abuse vary widely from transient adjustment reactions with mood and behavioral disorders to characterological problems and difficulty in reality testing. Many factors contribute to the variable effects of sexual abuse upon the victims. Carrol (1983) reports that the effects upon the victim are dependent upon four factors:

- 1.) The child's age and developmental status before the abuse and at the time of abuse.
- 2.) The nature of the abuse.
- 3.) The victim's perception of the meaning of the sexual interaction.
- 4.) The context in which the sexual abuse occurs -- the "abusive matrix".

Of critical importance is the context in which the abuse occurs. For example whether the abuse has been one of a single episode or violent assault by an unknown assailant or a chronic exploitative relationship with a family member or friend. The psychological effects may be more acute but of shorter duration with a single episode assault with a stranger but no less damaging than a prolonged, exploitive relationship with another family member. Often times the effects of abuse may present

as developmental regression or possibly worse, a fixation which may seriously distort the child's ability to relate to others as well as himself. Beale & Gottlieb (1983) have reported serious damage to children who have been sexually abused in their object relations and ability to establish important attachments to others. (Some of the developmental tasks of childhood and their disorders resulting from sexual abuse are reported in addendum A).

The "abusive matrix" also refers to the emotional environment in which the abuse occurs. Often a focus on the sexual act itself distracts from the even greater pathological consequence of the parent-child relationship. When the lack of an empathic, supportive relationship with the parent(s) exists and the relationship is characterized by exploitation, guilt and manipulation, the child often lacks the ability to develop an appropriate self esteem or identity to successfully separate emotionally from parents and develop a sense of self or adequate ego functioning. A number of studies and reports have focused on the latter difficulties which sexual abuse victims have had in establishing close, intimate interpersonal relationships. Almost all of the research conducted (Meiselman 1978) suggests that women who had been sexually abused as children, generally present with more emotional complaints as adults, demonstrated a higher percentage of anti-social disorders and are more likely or more "predisposed" to manifest problems associated with their family pathology than control groups.

Children also can suffer numerous physical effects from non-violent sexual abuse. (A number of studies which described the physical effects and problems of sexual abuse are reported in addendum B). A number of studies have been completed in recent years looking at the effects of sexual abuse upon children by adult women who entered treatment. Of particular interest here are the effects of sexual abuse upon the children of victims. Not only do many reports list the high percentage of sexual abuse among the children of sexually abused parents, but Outler & Haynes (Beal & Gottlieb) report that their study of failure-to-thrive babies indicated

that 40% of the mothers of failure-to-thrive babies had been sexually abused as children as compared to only 4% of the controls. Further evidence of the often cited multi-generational effects of abusive behavior and victimization.

The effects of sexual abuse upon children are multi-dimensional. There is no clear linear progression of damaging effects emotionally. The effects vary considerably and a complete clinical assessment involves at least four crucial steps: 1.) carefully review the child's age and developmental functioning prior to the onset, 2.) after the incident(s), 3.) the nature of the abuse and 4.) the response of the family and immediate environment in helping the child cope. We know that there is no casual relationship between sexual abuse and any particular psychiatric diagnosis. Yet, we also do know that all children and their families can be seriously effected and disturbed both as a result of sexual abuse. It is the same factors of understanding, support, trust, nurturance and healthy family boundaries and functioning which can greatly assist or help recompensate some families and their children to minimize the effects of sexual abuse.

The Offender

1. Myths

- the offender is a stranger
- the offender is an old man
- the offender is an alcoholic
- the offender is retarded
- the offender is homosexual
- the offender is a victim of provocative or seductive children
- the offender is a victim of a permissive society
- the offender is a crazy or psychotic

2. Realities

(From the work of Nicholas Groth; The sexual abuse of children and adolescence).

.....the victim almost always knows the assailant; unless it is a foreseeable, violent assault

.....100% of the offenders studied committed their first offense before the age of 40, 30% before the age of 30, and 5% before adolescence.

.....alcohol did not play a significant role

.....no significant rate of mental retardation

.....no significant rate to homosexuality

.....less than 5% displayed any clinical evidence of psychosis

(Regressed) Pedophile

As the name implies, regression is a temporary appearance of more primitive behavior, after more normative forms of expression have been attained. A (regressed child offender) originally preferred peers or adults, however these became conflictual in some important respect and were replaced by the child, in sexual interests and desires.

Throughout socio-sexual development the regressed offender expresses an appropriate peer interest, yet his development appears influenced and undermined by a sense of inadequacy that increase with adulthood. His self image and identity is further impaired by some challenge to his sexual adequacy or competency as a man. Crisis, (physical, social, sexual, marital, financial, vocational, etc.) exists which precipitates sexual involvement in a child, an impulsive and desperate act but is symptomatic of failure to cope or adapt with life stress. If there was any attraction to younger people in the past, it was experimental or situational or a functional disturbance. However, little research to date has been done on sexual offenders, the primary focus is from empirical data

derived from prison populations. The data has not progressed beyond clinical and statistical observation, mostly case reporting. However, what information is available suggests there are two patterns of Pedophile behavior, a fixed pattern of persistent behavior or a new activity, indicative of regressive behavior...

The regressed offender is often married and a situation develops which threatens this relationship. Feelings of being overwhelmed occur and he becomes involved with a child sexually; he is often distressed by this behavior and may experience feelings of guilt, shame, and disgust, etc. At the time of the offense he is often depressed, suspends his usual values and behaves in a way contrary to his usual behavior in an unsuccessful effort to cope with specific life issues.

Fixation

Is a temporary or permanent arrest of psychosocial maturation. A fixated pedophile is someone who from adolescence has primary or exclusively been attracted to younger people and this attraction has persisted throughout life; regardless of other sexual experiences.

As a teenage, he often avoids the usual patterns of socialization with peers, (dating, competitive sports) and as a result does not pursue mature sexual relationships. He may respond to sexual invitations but not pursue them. If they respond, they often depart from the norm. This individual is comfortable and satisfied in pedophilic behavior, that is to say it is not ego dystonic. Even when he is distressed, he feels a compulsion which cannot be avoided; there is no intense guilt or shame. Sex relations with adults are avoided out of fear of rejection and/or punishment; inadequacy; adults are not desirable, they do not "turn him on" in any way.

To this individual sexual and psychosocial adjustment with adults is not gratifying. Often this individual is seen as inadequate, someone who is often

overwhelmed by demands of life. This pattern is not a reactive one but an attempt and resolution to specific life issues in psychosocial development. He desires closeness and love and sees the victim as loving, open, affectionate, clear, undemanding, non-threatening, yet gratifying.

The Family

Some myths are that.....

.....it happens only with rural, isolated families in the "backwoods" of Maine or West Virginia

.....it happens only in poor families

.....it is the result of a flirtatious provocative daughter or step-daughter

.....it occurs only with a family with a psychotic or severely disturbed father

Unfortunately we know otherwise. (Speaking only of incest, in 1955 (Weinberg) there were 1.9 cases/per 1,000,000 population in the United States. In 1966 (American Human Association) there were 40 cases/per 1,000,000 population reported in the United States. This is not the result of increased behavior but greater still in identifying and reporting such cases. We now realize that):

.....sexual abuse occurs in all socio-cultural environments in this country

.....it is not a form of family pathology limited to poor or underprivileged S.E.S. families who "don't know any better".

.....it is the result of a variety of complex problems effecting the entire family and is not the responsibility of a sexually precocious adolescent.

.....sexual abuse is not correlated with psychotic behavior or mental retardation by a family member.

Summit and Kryso (1977) report that sexual abuse in families has particular antecedents and predictable consequences. They report that the parents in families where this form of abuse occurs usually lack impulse controls, are

under transient stress or may suffer characterological deficiencies and also suffer from a lack of functioning family boundaries.

James Kent in California has accumulated some interesting epidemicological data comparing the characteristics of families in which children are sexually abused to families in which children are physically abused. He reports that compared to physical abuse, sexual abuse more frequently occurs on weekends and at night, is more often reported by the child, less frequently leads to hospitalization, and rarely results in physical impairment. Compared to physically abused children, sexually abused children tend to be older, female, white, Protestant, and the product of normal pregnancies with normal developmental histories. Compared to mothers of physically abused children, the mothers of sexually abused children were more often white, married, long-time residents of their city, employed and of higher socio-economic status. In Kent's study, 31% of the mothers had themselves been sexually misused or abused as children. The fathers of sexually abused children tended to be older (90% were older than 31 years of age), white, long-time residents, and of higher socio-economic status. Twenty-six percent of the fathers had had previous psychiatric treatment. The fathers had themselves been abused as children about as frequently as was the case for fathers of physically abused children. Among siblings of sexually abused children, 50% of other children within the household had also suffered abuse.

Weinberg has written extensively on families in which there is incest. He has characterized different family patterns which corresponds to different categories of incest.

In families in which father-daughter incest occurs, the father tends to dominate and adversely influence the family by his sexual attitudes and his emotional instability. His intimidation and controlling and sometimes abusive

behavior account for his dominant position. Other persons within the family have been unable to successfully exert a restraining influence.

The family organization of brother-sister incest participants differ in that the father does not have a dominant position. He is often weakened, indifferent, preoccupied, or absent. The children showed lack of sexual restraint and parents inadequately supervise and limit their activities.

When both brother-sister and father-daughter incest occur in the same home, the family is usually more disorganized than in those families in which one form of incest has occurred. The female daughter-sister is often intensely sexually aggressive. The mother usually has a subordinate position.

Mother-son incest is the rarest form. In these families the mother is dominant while the father is subordinate or absent. Often the mother is widowed or separated. When the mother initiates the act, the relationship between mother and son is usually ambivalent with both hostile and dependent features. When the son is the aggressor the relationship may be very indifferent or very close. These patterns of family organization are theoretically characteristic of cases of incest, an extreme form of sexual misuse. Various gradations of individual and family pathology may be found which sometimes correlate with the severity of sexual misuse or abuse. In some highly disorganized families sexual abuse is an almost incidental finding amidst major deficits in the family's capacity to nurture, protect, and socialize its members. In more subtle cases of misuse, family structure may be more cohesive and pathology less severe.

III. The Development of a Social Policy

The Setting

The setting in which this situation occurs is in Central New Hampshire community and region which has a population of approximately 60,000 year round residents and swells to approximately 80,000 in the summer. Tourism and recreation are its major industries with light manufacturing and services its next most productive industries. The area geographically and business wise centered around its major city with smaller surrounding tourist, residential and agricultural towns nearby. A small college exists approximately twenty miles from the heart of the community and has little environmental influence upon the region.

This worker began employment at the catchment area's Community Mental Health Center approximately ten months prior to the writing of this report. Assuming the position of coordinator of Children and Youth Services with a mandate of "rebuilding" the Child and Youth Services as a viable outpatient service in the community. Staff shortages and underfunding had demoralized the Child and Youth staff, resulting in vacancies, a decreased ability to provide services and ultimately a decreased in referrals and utilization. The clinical staff in the Child and Youth Program is small; three and one half full time equivalents, including a part-time child psychiatrist. The entire outpatient clinical staff employs ten F.T.E.'s.

My original task was to complete the staffing and then cultivate our identity as a quality Child and Youth Outpatient Services, with an experienced staff trained with the expertise to identify, evaluate and treat children and their families with emotional or adjustment difficulties; as well as to develop a "preventative model" of community mental health, which emphasizes early identification,

education and consultation of those issues which are likely indicators of stress or conflict within the population. Thus, the primary objective of our service is the treatment of emotional disorders which effect children and families and the secondary objective is to provide education and consultation services in an effort to reduce the incidence of emotional disorders within the same population.

In my efforts to establish community liaisons with other professionals and to provide community consultations, I began to attend regular meetings of a Child Abuse Resource Team, which is a multi-discipline group of community agents and professionals interested in the problem of child abuse. The objectives of the group are twofold: One is to provide consultation and input to protective services and other professionals and para-professionals on cases involving child abuse. The second function is to serve as an advisory and task centered group to reduce the incidence of child abuse. Through my attendance at this group I am able to meet regularly with many of the significant providers of services to children in the area and participate in an established forum for advocacy and change.

In the period of time I was employed with the Center, I quickly realized the striking infrequency of referrals of cases of sexual abuse from the New Hampshire Division of Welfare, Child and Family Services Unit, (hereto referred to as the Division of Welfare), which is the organization mandated by New Hampshire Law to provide protective services for child abuse cases. The lack of referrals involving sexual abuse to our community mental health center suggested a problem in the identification of disposition of these cases by the Division of Welfare. If a problem is defined as a need not being met, then indeed the need of children and families involved in sexual abuse for therapeutic services was not being met.

The initial step then became the assessment of the problem: What was responsible for preventing the referral of families with sexual abuse to treatment? My assessment took the form of carefully reviewing the course of

events involved in all sexual abuse referrals to our Center, inquiring about those cases not referred cases by the Division for Services and listening to the Division of Welfare staff case presentations at our Resource Task Force meeting. Clearly a significant number of cases were being identified by the Protective Services but what followed the investigation or reported abuse was inconsistent and dependent upon the discretion of the individual Protective Services worker involved. The few referrals received by our Center were generated by a small minority of staff who identified the degree of the problem, the need for clinical intervention and usually responded to such cases in a consistent manner. The remainder of the staff often responded in a disorganized, inconsistent fashion which at times was detrimental to the emotional needs of the children and their families, often prolonging the trauma by separating the children from their families for excessive periods of time for protective purposes without a clear understanding of their emotional needs or a therapeutic approach to the family system issues which generated or perpetuated the problem.

The intervention strategy to address the problem was broad yet clear: A systemic approach was needed to address the problem of how to best respond to those sexually abused children and their families, to maximize the opportunity for successful treatment of the problems, while insuring the protection of the child. The knowledge base available in the treatment of sexually abusive families suggests that in addition to whatever individual pathology (e.g., pedophile, character disorder, impulse control problems, etc.) may be present in the offender, a significant family dysfunction is also present (e.g., role reversal, boundary confusion, marital discord, etc.). While numerous treatment approaches exist for the treatment of sexual abuse, a significant contribution to the treatment of sexual abuse in families by many (e.g., the Palo Alto group in California; Nicholas Groth in New Haven, Connecticut) stress the family disruption is of significant importance in the eventual therapeutic outcome. While intrapsychic disturbances in object relationships, trust, self esteem, etc. can and often do

occur with the victim as a result of sexual abuse, the guilt associated with disclosure, family disruption and social reactions can have an equally significant effect and are of immediate consequence. The treatment strategies offered by these theorists suggest an immediate referral to treatment, to combat the guilt, responsibility, and family disruption that often accompanies the extensive, delayed investigation and any subsequent court procedures. Too often the response to a sexual abuse investigation enhances an adversarial atmosphere where the emphasis is on protection of the child but removal of the child(ren) and criminal justice system contact, without the attitude or opportunity conducive to a therapeutic intervention occurs. The availability of treatment programs or procedures provides the offender with an option for acknowledging the problem and receiving help which is not non-punative. The goal of treatment is to encourage the admission of responsibility for the abuse, which removes the burden of guilt and any role reversal in the family; consenting to treatment which is limited in confidentiality to include the Protective Services worker, who is the agent empowered with responsibility for the present and continued safety of the child; and should begin immediately after disclosure to maximize the benefit of the disclosure and produce change in the family system. In all but the most extreme or dangerous situations, admission of responsibility precludes the necessity for removal of the child or offender, thus preventing further conflict and trauma for all members of the family, including the victim.

Such an approach emphasizes the importance and necessity of a systemic response to the problem. Because the sexual abuse of children involves a matrix of psychological factors along with the social, legal and medical input, the procedures involved in investigating and treating the family should likewise involve systemic input and coordination from all of the same agencies.

The Task

The first task involved in meeting this problem was addressing the level on intervention required to best deal with the problem. While the focus of the problem could clearly be established on the mezzo level of group or organizational responsibility from within the Division of Welfare, yet both macro and micro levels are also involved. This particular problem was affected by those individual offenders and families which contributed to the problem and to the macro levels of institutional and community attitudes and behavior which (perhaps unintentionally) perpetuated the "taboo" and prevented open, frank dialogue regarding more effective means of treating the problem. It was evident that by addressing or targeting any single level of responsibility would be incomplete. If an intervention were made at the micro level with these individuals or their families alone to provide the direct treatment and intervention necessary to help them deal with the problem and its effects, the efforts would perhaps effectively address a very small minority of cases and then only as the psychopathology effects them on their family system personally, without addressing the environmental transaction which plays such a significant role in this particular form of systemic pathology. An intervention (i.e., consultation, education, supervision, etc.) at the mezzo level with the Division of Welfare only, fails to address the individual needs for therapeutic intervention or the larger community's role in providing a comprehensive, systematic response to this psychological, social and legal problem. Finally, to address the macro level only would almost certainly fail to affect the organizations and groups directly responsible for addressing and responding to the problems and certainly would have no direct impact on the individuals involved. The lines of responsibility and action in the cases of sexual abuse were not clear enough to effect change on the micro level by an intervention with the macro influences only. The

intervention strategy to the problem was directed on the micro level with the abusive families directly; on the mezzo level through the consultation and suggestions to the Division of Welfare as to some the approach and response to these families and their children; finally by developing a community based plan of action involving police, the courts, the medical and social service systems (and ultimately we hope to effect change in the N.H. laws governing sexual abuse matters), the macro level of intervention is addressed.

The next procedure involves the method and intervention employed. As previously noted, the subsequent environment response and treatment of sexual abuse within a family involves a matrix of legal, social, psychological and medical input. To effectively respond and treat the problem, the method of intervention likewise involves systemic approach within the community to

- 1) establish a broad community-based response to the problem of the sexual abuse of children;
- 2) **to develop an** effective and consistent protocol or method for action in such cases which guarantees the safety of the child and prevents continued abuse and/or trauma; and
- 3) maximizes the opportunity for a positive therapeutic intervention with the child and family.

The linear progression thus moves on from the knowledge base of the problem and on to the values and tasks utilized to effect change (see diagram I).

The forum for such changes was this workers role in the Sexual Abuse Task Force. I declined an invitation to serve as coordinator of the Task Force, (a capacity I had served in another community) due to time constraints and the desire to concentrate my efforts on the specific problem of sexual abuse. Continued efforts to articulate the tasks, responsibilities and necessary procedures in such cases, resulted in the desire of the committee to establish a subcommittee to address the problem and I accepted an invitation to serve as coordinator of the subcommittee. By a mutual process, the subcommittee gained the participation of the following: the Protective Services supervisor at the Division of Welfare; the female police officer who investigates cases of sexual

abuse in the areas only large city; an attorney who frequently is involved in child and family cases serving as the child's legal representative (guardian ad litem); and a Child and Youth Probation Officer. Our task was defined as an effort to develop a protocol for responding to and treating sexual abuse cases in our catchment area.

The selection of these participants was crucial for the development of the protocol. We, with the exception of a pediatrician, represented perhaps all of the key elements in the systemic response and treatment of the sexually abused child. It was within this group that the skills and tasks of social work leadership were demonstrated. The knowledge base and values had been utilized in the steps that lead to the formation of the subcommittee. The skills and process used within the subcommittee became the ones of clarifying, mediating, documenting, facilitating, and educating. The worker needed to involve all members into participating and collaborating in a joint effect, utilizing all of our various expertise and knowledge in designing an effective protocol. The mediating, clarifying and group process skills were of paramount importance in this phase of the task. The combined skills of all subcommittee members were necessary and were utilized in facilitating a comprehensive systemic approach to the problem that would be usable in our setting. The main task of the author was to facilitate and process the expertise of the group to culminate in a documented protocol. Knowing the personal, professional and philosophical dynamics involved in the group, I needed to focus on a brief format to encourage participation and opinion initially, to be followed by review and a procedural analysis of a protocol and finally an editing phase to smooth out detail and implementation. The tasks of documentation, structuring and reframing input and procedure resulted in the (continuing) draft of our protocol.

The Roles of the Social Worker

The activities involved were varied and can be viewed in any number of ways. Germaine's (1979) description of elevating the role of "mediator" to primary position is particularly applicable in this situation. The need exists in the community described to more effectively bring the client (sexually abused children and their families) and the community's institutions (social service, mental health, legal, medical, etc.) "into a more congenial and beneficial juxtaposition" (p.67). The problem described was not primarily one of lack of available resources, which is often the case. While this does not by any means imply that an excess of services exists or that more cannot be effectively utilized to better cope with the problem, rather the problem was more of effecting a smooth transaction between existing services and the client's needs. The primary task for the social worker was the facilitation on a systems level, of mediating between client(s) and the community institutions into a more effective and beneficial relationship. The ability to accomplish that task was aided by two very important factors: First of all, my ability to function in an administrative capacity allowed me the opportunity to provide consultative services to a community based Resource Team (Task Force) which enabled me to extend my time in an indirect service activity. Pressure of accountability and service delivery make this an increasingly difficult activity for clinical social workers practicing in group practices, community mental health or community supported programs. Perhaps the most important obstacle in elevating the mediating role are the financial constraints. An economic reality of social work practice is that all activities must be financially supported in some capacity. My administrative/consultative activities (50% of my contract) enables me to accomplish this end. Otherwise, more creative management is necessary to justify activity in non-reimbursable activities, such as mediating tasks. One means of implementing this practice is to creatively seek funding sources to support these activities.

The political/economic climate is not presently conducive to such activities but efforts need to continue to find funding sources to utilize the same problem solving and leadership skills articulated in this paper, with those empowered with the finances to support such activity. It is a role for social work administrators to use some of the same knowledge base, skills, tasks and process with those who make fiscal decisions: To educate those that govern and make policy and financial decisions as to the most cost effective means of providing services. Research efforts to demonstrate the effectiveness of secondary or preventative services in particular situations need to be conducted to enhance cost-effectiveness where services are limited (i.e., rural communities). If we believe that mediating advocacy role is the treatment of choice in cases/situations where a transactional problem exists between client and community, then a similar role should be adopted between community supported services (client) and their funding sources (community). The mediation between both needs to occur in order that the community funding sources can better learn and understand our situation and expertise with our clients in order to more effectively (both clinically and financially) function ourselves.

IV. Conclusions

The ultimate success or failure of our sexual abuse protocol remains to be determined. Upon completion of our efforts to design an effective and comprehensive approach to the problem we need cooperation from the local County-Attorney. According to New Hampshire Law all cases of sexual abuse must be referred to the County Attorney for review and disposition. Unfortunately, the existing law leaves a significant degree of individual discretion up to the County Attorney to determine the legal course of action to be taken. No formal operations procedure exists for these individuals and the legal consequences are often left to the County Attorney's reaction to the case, recommendation of

the Protective Services workers, other influences or factors. Our approach at this time is to present a completed protocol to the County Attorney for review and inspection, hoping the elicited support and cooperation from the development of a well designed, consistent approach to the problem which protects the child, maximizes the therapeutic opportunities to those most likely to benefit from them and advocates for the continued legal input and involvement necessary to insure compliance and cooperation. Like any system, one component and its functions directly relates to the others and the cooperation and compliance of the County Attorney is crucial to the effective implementation of the protocol.

The leadership tasks and role of clinical social work involved in this problem suggests a wide range of activities. I believe that this particular case demonstrates the combined effort and skills originating from a practice base and evolving to a community organizational role. If social workers are to assume leadership positions within their respective area of expertise (e.g., clinical, community organizations, etc.), they cannot divert too far from their primary areas of skills and influence without risking a loss in status associated with a lack of a specific knowledge base.

Yet, some of the better trained and more experienced social workers can effectively influence areas outside their particular area of expertise, particularly when using that expertise and skill in addressing issues outside their usual area of practice. The application of clinical skills in an effort to utilize a combined locality development/social planning model in a community organizational task, such as the one described in this paper, can be an exercise in leadership skills. Dolgoff (1981) suggests, an implicit and evolutionary model of change and influence can occur and produce an equally effective change without an explicit policy statement or articulated policy change. The implication is that social work leadership skills are influential and effective in facilitating change or reinforcing the status quo, indicating the need to constantly assess and recognize

our value systems.

The systemic implementation of a sexual abuse protocol is a clinically and organizationally sound approach to effectively deal with the sexual abuse of children and their families in the community described in the preceeding pages. The crucial elements for consideration are the facts that it is the systemic reaction and measures which contribute significantly to the ultimate effects on the child and family and as a result these same elements must be incorporated into any community based approach to insure its effectiveness.

The application of this strategy of intervention is similar to that used in direct clinical service. The knowledge base of how to treat sexually abusive families and how to assess a systemic dysfunction in a service delivery system are the cornerstones of this intervention. The progression then moves to the value base of protecting children from further abuse while providing an opportunity for treating individual or family pathology. The skills and tasks used in the clinical intervention form the basis for treatment of the conflict and disorders while similar skills are used to facilitate changes with the systemic environment to develop and implement a community based protocol for change. Finally, the process methods help to promote change and enhance adaptation.

The methods utilized to address the problem and develop the protocol are based on a similar approach to a clinical intervention, a problem is identified, and understanding and knowledge of the problem developed and a strategy or treatment plan put into effect to promote change.

Many tasks of our Sexual Abuse Resource Team remain. Further education tasks and policy statements regarding the psychological and legal effects of court room testimony upon children are needed. Clinical research as to the effects of parental separation following disclosure of sexual abuse is also needed to increase our understanding of the trauma associated with sexual abuse and the means to restructure children and their families. Careful examination

and research as to the effectiveness of (our own, as well as others) protocols is also needed. In many respects the tasks are never complete and the skills used to address them are a continuous and evolving process within itself.

Diagram I

Problem: Treatment of sexually abused child in rural community; a systemic approach to the development of sexual abuse protocol.

1. <u>Knowledge base</u>	2. <u>Values</u>	3. <u>Skills & Tasks</u>	4. <u>Process</u>
- Understanding of the problems of sexual abuse	- Protecting children from abuse while attempting to offer the most effective and therapeutic intervention	- Facilitating change - Educating others as to the critical issues involved in treatment - Empowering the protective services staff and others to move effectively to intervene and refer	- Evaluate the problem - Mediate role confusion - Facilitate a procedure
- Knowledge of treatment modalities		- Clarify roles	
- Critical analysis of systems		- Document tasks and responsibility	
- Assessment of the problem involved in facilitating proper treatment		- Provide support to others involved	
		- Educating others to the psychopathology of individuals, families and environment	

-----Levels of intervention:-----

Macro

Macro

Macro

Macro

Mezzo

Mezzo

Mezzo

Mezzo

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